8. HOSPICE

This section describes Medicaid's coverage of Hospice. It tells you about:

At the end of the section are some of the questions often asked about Hospice and the answers to those questions. See Hospice Q & A (page 8-15).

8.1 What Hospice Covers

Hospice is a package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy. The hospice services are related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility or a hospice inpatient unit. They also may be provided in a hospital or nursing facility under arrangement with the hospice agency. To be considered a nursing facility patient, the patient must be in a Medicaid-certified bed.

8.1.1 Services

The following services are included under Hospice when the service is related to the patient's terminal illness. Combinations of these services are provided as needed and according to the Plan of Care (POC). The first three services are core services provided by hospice employees. Physician specialty services and the other services may be provided under arrangement with the hospice agency.

- Nursing care.
- Medical social services.
- Counseling services for the patient, family members and others caring for the patient. Counseling, including dietary counseling, may be given to train the patient's family or other unpaid caregiver to provide care. It also may be provided to help the patient and those caring for the patient adjust to the patient's approaching death. (Although you are required to provide bereavement counseling for the patient's family after the patient's death, you may not bill for any service provided after the date of death.)
- Physicians' services provided by a licensed doctor of medicine or doctor of osteopathy for administrative, supervisory and group activities, such as participation in establishing Plans of Care, are included in the Hospice rates. Patient specific professional (direct care) services are billed directly to Medicaid by the providing physician. This includes services of both consulting and attending physicians and is not based on whether the physician is an employee of the hospice.
- Home health aide and homemaker services. Home health aides may do personal care tasks. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the patient to carry out the POC.
- Physical therapy, occupational therapy and speech-language pathology services for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.
- Short-term inpatient care (general and respite) in a hospice inpatient unit, or a hospital or nursing facility under contractual arrangement with the hospice agency.
- Medical appliances and supplies, including drugs and biologicals. The drugs are those used primarily for pain relief and symptom control related to the terminal illness. Appliances include DME as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided for use in the patient's home while the patient is under hospice care.

- Ambulance services that are related to the palliation or management of the patient's terminal illness.

8.1.2 Levels of Care

Each day of a patient's coverage is classified at one of four levels of care. The type and intensity of services the patient needs on that day determine the level.

- **Routine Home Care** is the basic level of care that is provided to support a patient. It is provided in a private residence, a hospice residential care facility or an adult care home. It also may be provided in a nursing facility if the facility has a contractual arrangement with the hospice agency.

- **Continuous Home Care** is provided during a medical crisis -- that is, a time when the patient's physician believes that the patient needs continuous care, primarily nursing care, to achieve palliation or management of acute medical symptoms.

  - The patient must need care for at least eight hours of the calendar day (the hours may be split into two or more periods during the day);

  - Nursing services by an RN or LPN must be provided for more than half of the hours of care in a day; and

  - Homemaker and home health aide services may supplement the nursing care.

- **Inpatient Respite Care** is short-term care to relieve family members and other unpaid caregivers caring for a patient in a private residence. Respite may be provided only on an occasional basis for up to five consecutive days at a time. It is provided in a hospice inpatient facility, or a hospital or nursing facility under arrangement with the hospice agency. The hospital or nursing facility must meet the special hospice standards for staffing and patient areas.

- **General Inpatient Care** is for the management of symptoms or to perform procedures for pain control that cannot be performed in other settings. The care is provided in a hospice inpatient facility, a hospital or a nursing facility under arrangement with the hospice agency. The hospital or nursing facility must meet the special hospice standards for staffing and patient areas.

  ***NOTE**: Payment for inpatient respite care and general inpatient care is limited. See 8.15.4.*

8.1.3 Benefit Periods

A patient or the patient's representative elects Hospice coverage for a "benefit period." The benefit periods are available in the following sequence:

- An initial 90 day period;

- A second 90 day period;

- Followed by an unlimited number of 60 day periods.

See 8.6 for the linkage between Medicaid and Medicare benefit periods.

8.2 Who's Covered

Whether a patient is covered depends on four factors:

8.2.1 Type of Medicaid Coverage

A patient must be covered under:

- Regular Medicaid coverage – that is, have a **BLUE** card; or
- Pregnant Women coverage -- that is, have a **PINK** card and require Hospice due to a pregnancy-related condition. Prior approval is required – see 8.3.1.

***NOTE**: If a patient is a Medicaid managed care participant or a CAP client, see Section 2 for possible coverage restrictions.*

8.2.2 Patient's Medical Status

A patient must be terminally ill - that is, have a life expectancy of six months or less - as certified by his physician.

8.2.3 Patient's Location

Hospice may be provided to a patient residing in:

- A private residence;
- A hospice inpatient unit;
- A hospice residential care facility;
- An adult care home; or
- A hospital or nursing facility that has a contractual arrangement with the hospice agency.

***REMEMBER:** To be considered a nursing facility patient, the patient must be in a Medicaid certified bed.*

8.2.4 Waiver of Right to Other Medicaid Coverage

During the time a patient elects Hospice, he waives Medicaid coverage of other services for the treatment of his terminal illness and related conditions except for:

- Certain non-skilled services for which there is no Medicare equivalent, such as some CAP services; and
- Physicians' services provided by a physician who is not employed or paid by the hospice for providing those services.

***Example 1:** Mr. Schwartz, a patient with Medicare and Medicaid coverage participating in CAP-DA, elects Hospice. The hospice coordinates its services with Mr. Schwartz' CAP-DA case manager. The CAP-DA case manager will continue to coordinate Mr. Schwartz' care and approve Medicaid payments for CAP services that do not duplicate Hospice coverage.*

Example 2: *Ms. Lee, a patient with Medicaid coverage, is referred for Hospice care by her family physician, Dr. Palmer. After Ms. Lee elects Hospice, Dr. Palmer continues to bill Medicaid for professional services furnished to her.*

Example 3: *West County Hospice has a contractual arrangement with Memorial Hospital to provide inpatient care for hospice patients. Ms. Sanders, a Medicaid hospice patient, enters the hospital for management of symptoms related to her terminal illness. Dr. Platania, a pulmonologist with the hospital, examines Ms. Sanders and provides consultation regarding her treatment. Dr. Platania may bill Medicaid for direct patient care services provided to Ms. Sanders.*

See 8.5 for guidance on applying these coverage requirements.

8.3 Limitations

8.3.1 Hospice Participation Reporting and Prior Approval

Your Medicaid payment for Hospice is dependent on your prompt reporting of Hospice participation. You have to notify EDS when a Medicaid recipient initially elects the Medicaid Hospice benefit, begins a new benefit period, transfers to another hospice, and revokes the benefit or is discharged. This includes Medicare/Medicaid Hospice patients in nursing facilities for whom Medicaid is paying room and board. The reporting also allows all Medicaid providers to access Hospice participation information through Automated Voice Response (AVR).

Prior approval is not required unless a patient has a PINK card, which indicates MPW coverage. See 8.5, Step 3, to learn about prior approval for MPW patients.

8.3.2 Amount of Service

The amount of service is limited to that which is medically necessary as determined by Medicaid policies and prescribed by the physician on the POC.

8.3.3 Other Limitations

A Hospice patient is not covered for any of the following Community Care Services when the service is to be provided for the terminal illness and related conditions. A terminally ill patient may elect Hospice or seek coverage for the following services for which he qualifies.

- PDN
- HIT
- Home Health Services
- DME
- PCS

In addition, if a patient is eligible for Medicare, he must elect Hospice coverage under both programs at the same time. The election periods must be concurrent. See 8.6.

See 8.7 for guidance on coordinating with other services and 8.15.4 for limitations on payment for inpatient care.

8.4 Who May Provide Hospice

You may provide Hospice if you are enrolled with DMA as a Hospice provider. To be enrolled, your agency must be a Medicare-certified hospice agency within North Carolina with a license from the Division of Facility Services to provide hospice services.

8.5 Getting Coverage

The following outline the basic steps for a patient to get Hospice. The steps are in the order that they are usually accomplished.

Step 1 Receive Referral

A patient may be referred for Hospice by his attending physician, a member of his family or a friend. Hospital discharge planners or social workers may also refer a patient for Hospice. When the referral is from someone other than a physician, contact the attending physician to confirm that the patient has a medical prognosis of six months or less to live.

Step 2 Assess Appropriateness

After consulting with the patient's physician, have a member of your interdisciplinary team visit the patient to assess if Hospice is appropriate. Determine if your agency can provide the services needed by the patient. Resolve any questions or concerns you have about the patient's care before proceeding. Contact the attending physician, family members or others as appropriate.

Step 3 Verify Medicaid Eligibility

Follow the guidance in Section 3 to verify Medicaid eligibility. When checking the color of a patient's Medicaid ID card, remember the following:

Blue: A patient may be considered for Hospice.

Pink: Covers only pregnancy-related services as defined in Section 2. Hospice must be related to the pregnancy and must have prior approval to be covered. Before providing services to a patient with a PINK card, get prior approval by following the procedures in Appendix E.

Buff: A patient is not eligible for Hospice as a Medicaid service. See 2.15 for Medicaid's coverage of Medicare co-insurance and deductibles.

***REMEMBER**: Check all of the other information on the card - such as eligibility dates, insurance information and other important items noted in Section 3. If the card shows that a patient participates in a Medicaid managed care program or CAP, coverage may be restricted. See Section 2.*

Step 4 Check Medicare Status

Determine if the patient has received, is receiving or is eligible to receive Medicare Hospice coverage. Follow the guidelines in 8.6 if the patient is a Medicare beneficiary.

Step 5 Get Medicaid Election Statement

Before providing services, have the patient or the patient's representative sign a hospice agreement that includes a Medicaid Hospice election statement. The Medicaid statement may be on a separate form, combined with the Medicare election statement or may be part of your agency's usual election form.

The Medicaid statement must:

- Declare the patient's intent to receive Medicaid Hospice coverage;
- Designate the hospice agency that will provide care;
- Provide the patient's acknowledgment that he understands the palliative rather than the curative nature of hospice care as it relates to the terminal illness;
- Include the patient's waiver of certain Medicaid services related to the terminal illness;
- State the effective date of the election period; and
- Be signed by the patient or the patient's representative.

REMEMBER: *If a patient has Medicare coverage, he must elect Medicare and Medicaid Hospice coverage at the same time. Also, if a patient has been covered by Medicare Hospice, the point at which he enters Medicaid Hospice is set in relation to the Medicare benefit period. See 8.6.*

Step 6 Report Hospice Participation

Call the EDS PA Unit to report Hospice participation no later than the sixth day after the start of the benefit period (day of report plus six previous days).

EXAMPLE*: Jerry Jones elects Medicaid Hospice on March 4. His Hospice participation must be reported to EDS no later than March 10.*

Phone EDS at 1-800-688-6696 or 919-851-8888 – when you reach EDS, press 2, and then press 9, to be connected to the appropriate staff in the PA Unit. Provide the following information:

- The patient's Medicaid ID number
- The name of the patient as it appears on the patient's Medicaid ID card
- The benefit period start and end dates
- The ICD-9 code for the primary diagnosis related to the terminal illness
- Your Medicaid provider number
- The name of your hospice as listed on your Medicaid provider participation agreement
- Your name and phone number

EDS will give you a system generated confirmation number. The number is unique to the patient and the hospice. It is effective through the last day of the benefit period, unless the patient revokes Hospice, is discharged or transfers to another hospice before that date. Record the number and date of your call in the patient's file – it is your proof that you contacted EDS.

NOTE: *If the patient is a Medicare/Medicaid patient and you do not expect to bill Medicaid – that is, the patient is being served outside of a skilled nursing facility, reporting Hospice participation is optional. Remember to report participation if the person later enters a nursing facility.*

REMEMBER: *Also report when a patient begins a new benefit period, revokes Hospice, is discharged, or transfers to another hospice agency. See 8.11, 8.12 and 8.14.*

Step 7 Develop the POC

Before beginning care, have members of your hospice interdisciplinary team develop a POC. One of the team members developing the POC must be a physician or nurse.

- Within two calendar days after the patient assessment, all other team members must review the POC and revise it as needed.
- The POC is then signed by either the hospice medical director, a physician member of the hospice interdisciplinary team or the patient's attending physician.

Step 8 Get Physician Certification of Terminal Illness

No later than two calendar days after the effective date of the election period, you must obtain the physician's verbal or written certification of the terminal nature of the patient's illness. If the certification is verbal, your agency must have the physician's written certification of the terminal illness in your record prior to submitting a claim. The certification must:

- State that the patient has a medical prognosis of six months or less to live;
- Be signed by either the physician member of the hospice interdisciplinary team or the hospice medical director; and
- If the patient has an attending physician, be signed by that physician.

8.6 The Medicare/Medicaid Connection

If a patient is on regular Medicaid (has a **BLUE** card) and is also a Medicare beneficiary, Medicare coverage will be indicated in the insurance data block of the card. Medicaid and Medicare Hospice must be elected simultaneously, but Medicare is the primary payer. Bill Medicare for the dually-eligible patient's Hospice care. If the dually-eligible patient is in a nursing facility, you may bill Medicaid for the appropriate long term care room and board rate. See 8.15.1.

Coordinate benefit periods between the programs as follows:

- **Patient Has Not Previously Received Medicare Hospice:** Begin both coverages simultaneously at the beginning of the first benefit period.
- **Patient Currently Receiving Medicare Hospice:** Begin Medicaid Hospice at the same point in the benefit period as Medicare Hospice. For example, if a patient is at day 45 of the first benefit period for Medicare, begin Medicaid coverage at the same point.
- **Patient Has Received, But Is Not Currently Receiving Medicare Hospice:** The patient resumes Medicare at the next available benefit period and begins Medicaid coverage at that same period. For example, if the second period is the next available Medicare period, the patient begins Medicaid coverage at the beginning of the second period

REMEMBER: *Report Hospice participation according to the instructions in Step 6 of 8.5 if the patient is in a nursing facility. Call the EDS PA Unit to report Hospice participation no later than the sixth day after the start of Medicaid coverage (day of report plus six previous days).*

8.7 Coordinating Care

Coordinate services to ensure the best care for a patient while avoiding duplication or overlap.

- **Services Not Related to the Terminal Illness:** If a patient is receiving care not related to his terminal illness, coordinate the provision of care with those providers.

- **CAP:** Contact the CAP case manager if your patient participates in CAP. CAP participants have a two-letter code in the CAP block of the Medicaid ID card. CAP clients have a cost limit for Medicaid home and community services. The cost limit may prevent a patient from receiving Medicaid Hospice and CAP at the same time. See Section 2 for information about CAP.

8.8 Delivering and Supervising Care

Provide Hospice according to a patient's POC. Use your employees to provide the core services. Other covered services may be provided by your employees or under arrangement. You are responsible for all of the services. Supervise the delivery of care according to law, regulations and professional practices.

8.9 Providing Care to Nursing Facility Residents

You may provide Hospice to a nursing facility resident if you have a contractual arrangement with the facility. The contract must specify that your agency is responsible for the professional management of the patient's hospice care and that the facility agrees to provide room and board. Other details of patient care are included in the agreement.

When a nursing facility resident elects Hospice, your agency assumes responsibility for collecting the Patient Monthly Liability (PML) from the patient. Inform the local DSS of the patient's election of Hospice and the DSS will send your agency notification of the PML amount on a DMA-5016. You may arrange for the nursing facility to act as your agent in collecting the PML. See 8.15.3 for information on how the PML affects your payments for Hospice care.

REMEMBER: *If you have a Medicare/Medicaid patient entering a nursing facility, you must report the Hospice participation to EDS to be eligible for Medicaid payment of the room and board. Call the EDS PA Unit to report Hospice participation no later than the sixth day after date of admission to the nursing facility (day of report plus six previous days) using the same process as you would for a new Medicaid patient. See Step 6 in 8.5 for details*

8.10 Monitoring Care

Members of your interdisciplinary team monitor the patient's condition and initiate changes in the POC as needed. The patient's attending physician also participates in this process. Members of the interdisciplinary team must review and update the POC at least every two weeks to be sure that the patient's needs are met. Document each review in the patient's record.

8.11 Recertifying Terminal Illness and Reporting Continuing Participation

The patient's terminal illness must be recertified at the beginning of each benefit period. No later than two calendar days after the beginning of the period, you should obtain the physician's certification of the terminal nature of the patient's illness. The certification must:

- State that the patient has a medical prognosis of six months or less to live; and

- Be signed by either the physician member of the hospice interdisciplinary team or hospice medical director.

In addition, no later than the sixth day after the start of the benefit period (day of report plus six previous days), call the EDS PA Unit to report continuing Hospice participation. Phone EDS at 1-800-688-6696 or 919-851-8888 – when you reach EDS, press 2, and then press 9, to be connected to the appropriate staff in the PA Unit. When contacting the EDS PA Unit, provide the following information:

- The patient's Medicaid ID number
- The name of the patient as it appears on the patient's Medicaid ID card
- The benefit period start and end dates
- The ICD-9 code for the primary diagnosis related to the terminal illness
- Your Medicaid provider number
- The name of your hospice as listed on your Medicaid provider participation agreement
- Your name and phone number

EDS will give you a system generated confirmation number. The number is unique to the patient and the hospice. It is effective through the last day of the benefit period, unless the patient revokes Hospice, is discharged or transfers to another hospice before that date. Record the number and date of your call in the patient's file – it is your proof that you contacted EDS.

8.12 Hospice Revocations and Discharges

A patient's participation in Hospice may cease due to the patient revoking Hospice or your agency discharging the patient. ("Discharge" refers to a patient who is being discharged from your agency and Hospice coverage – see 8.14 for information about transfers between hospice agencies.)

- A patient may revoke his Hospice election at any time by completing a signed revocation statement. Medicare/Medicaid patients must revoke Hospice for both programs simultaneously. The statement must say that the patient revokes the Hospice election and include the effective date of the revocation. The effective date cannot be earlier than the date the patient signs the revocation statement. By revoking Medicaid Hospice coverage, a patient:
  - Forfeits any remaining days of coverage in the current benefit period after the revocation date; and
  - Resumes coverage of the waived Medicaid benefits as of the revocation date.
- Your agency may discharge a patient in accordance with applicable law, regulation and policy.
- You may bill for the date of discharge or revocation.

Because Hospice participation information potentially affects Medicaid payment for other services, it is very important to promptly report when a patient revocation or discharge. Call the EDS PA Unit to report revocations and discharges. Phone EDS at 1-800-688-6696 or 919-851-8888 – when you reach EDS, press 2, and then press 9, to be connected to the appropriate staff in the PA Unit. Make the report no later than the sixth day after the action (day of report plus six previous days). Provide the following information:

- The patient's Medicaid ID number
- The name of the patient as it appears on the Medicaid ID card

- The date of the revocation/discharge
- Your Medicaid provider number
- The name of your hospice as listed on your Medicaid provider participation agreement
- Your name and phone number

Ask for the initials of the person accepting your information in the EDS PA Unit. Record the person's initials and the date of your call in the patient's file – it is your proof that you contacted EDS.

8.13 Re-Electing Hospice After a Revocation

If a patient wishes to resume Hospice, the patient or the patient's representative re-elects Hospice for the next remaining period. Consider the patient the same as a new patient, and follow the steps in 8.5. This includes a new election statement, a new POC, a new physician certification, and a participation report to EDS.

8.14 Changing Agencies

A patient may change hospice agencies between benefit periods. A patient may also change the hospice agency once during each benefit period. To change agencies during a benefit period, the patient gives a signed statement to both the current agency and the new agency that:

- Indicates the patient's intent to change agencies;
- Shows the name of the current agency;
- Shows the name of the new agency; and
- States the effective date of the change.

Coordinate the transfer with the attending physician and any other care providers to ensure continuity of services. The new agency assumes responsibility for the patient's care on the effective date of the change and bills for that date of service. The day before the effective date is the last date of service billed by the old agency. The new agency may use the existing POC or develop a new one.

Payment to the new agency depends on a report of the transfer to EDS. The new agency reports the transfer. The initiation of the new agency's confirmation number will automatically end date the previous agency's number. Make the report no later than the sixth day after the date of transfer (day of report plus six previous days). When contacting the EDS PA Unit, provide the following information:

- The patient's Medicaid ID number
- The name of the patient as it appears on the patient's Medicaid ID card
- The start date for services from your hospice and the end date of the benefit period
- The ICD-9 code for the primary diagnosis related to the terminal illness
- Your Medicaid provider number
- The name of your hospice as listed on your Medicaid provider participation agreement

- Your name and phone number

EDS will give you a system generated confirmation number. Record the number and the date of your call in the patient's file – it is your proof that you contacted EDS.

***REMEMBER**: An agency change is not a revocation of Hospice. When a change occurs during a benefit period, the patient completes the period with the new agency*

8.15 Getting Paid

Instructions for filing claims are in Section 14. Key points to remember when filing Hospice claims follow.

These instructions are for regular Medicaid - that is, **BLUE** card - recipients when Medicaid is the primary payer. The instructions also apply when you have prior approval to provide Hospice to an MPW recipient – a recipient with a **PINK** card – when Medicaid is the primary payer. See 2.16 for information on billing for Medicare-Aid recipients.

8.15.1 What May Be Billed

You may bill for Hospice Services provided according to Medicaid policies and procedures. Bill according to the level of care for each day of the benefit period.

REMEMBER: There have been two significant changes in Hospice billing since 1999

1. *Effective April 1, 1999, date of service, billing for Routine Home Care and Continuous Home Care is based on the location of the patient for each date of service. Billing for dates of service prior to 4/1/99 is based on the location of the hospice agency. Billing for the other Hospice services continues to be based on the location of the hospice agency.*

2. *Effective May 1, 2000, date of service, there must be a confirmation number active for the date of service for a Hospice claim to be processed for payment. A Hospice claim for a patient without an active confirmation number on the date of service will be denied. The procedures provide you with a grace period to report Hospice participation. Claims for dates of service in the grace period will be paid. For example, if you report on August 27 that a patient elected Hospice on August 18, claims beginning with August 21 date of service will be processed for payment. Claims for August 18 through August 20 will be denied. (Do not enter the confirmation number on the claim.)*

- **Private Residence, Hospice Residential Care Facility or Adult Care Home Patient**

  What you bill depends on the level of care provided on the date of service.

  - Bill the Routine Home Care rate for each day that this care is provided. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing.

  - Bill the Continuous Home Care rate for each hour that this care is provided. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing.

    ***REMEMBER:** You may not bill Continuous Home Care on the same day as Routine Home Care. See 8.1.2 for the Continuous Home Care requirements.*

- **Inpatient Respite Patient**

  Bill the number of days that a patient receives Inpatient Respite, beginning with the date of admission. Use the location of the hospice agency on the date of service as the basis for billing.

  Bill the date of discharge at the appropriate home care rate, unless a patient dies as an inpatient. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing the appropriate home care rate. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing the appropriate home care rate. If a patient is discharged as deceased, bill the inpatient respite rate for the date of discharge.

  REMEMBER: *There is a five-day limit on Inpatient Respite. If the patient remains in the facility longer than five days, bill the extra days at the Routine Home Care rate.*

  See 8.15.4 for additional information on Inpatient Care.

- **General Inpatient Care Related to the Terminal Illness**

  Bill the number of days that a patient receives General Inpatient Care, beginning with the date of admission. Use the location of the hospice agency on the date of service as the basis for billing.

  Bill the date of discharge at the appropriate home care rate unless a patient dies as an inpatient or discharge is delayed while a patient awaits nursing facility placement. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing the appropriate home care rate. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing the appropriate home care rate.

  - If a patient is discharged as deceased, bill the Inpatient rate for the date of discharge.

  - If discharge is delayed while a patient awaits nursing facility placement, bill the General Inpatient rate for up to three days. Bill any subsequent days as if the patient is in a nursing facility - that is, the Routine Home Care rate plus the appropriate long term care rate to cover room and board. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing.

  See 8.15.4 for additional information on inpatient care.

- **Long Term Care (Nursing Facility) Patient**

  Your billing depends on whether a patient receives Medicare.

  - **Medicaid Only:** Bill for Routine or Continuous Home Care, as appropriate. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing. Also, bill the long term care rate based on the location of the hospice agency to cover the room and board. You pay the nursing facility according to your contract.

  - **Medicaid and Medicare:** Bill the long term care rate based on the location of the hospice agency for each day to cover the room and board. Bill Medicare for Routine or Continuous Home Care, as appropriate. You pay the nursing facility according to your contract.

- **Patient Hospitalized for Condition Not Related to the Terminal Illness**

  The hospital is paid for the patient's inpatient care. You bill the Routine Home Care rate for each day that this care is provided. Beginning 4/1/99 date of service, use the location of the patient on the date of service as the basis for billing. For dates of service prior to 4/1/99, use the location of your agency as the basis for billing.

8.15.2 Units of Service

The unit of service is a calendar day, except for Continuous Home Care. The unit for Continuous Home Care is an hour.

8.15.3 Payment Rate

Your payment is calculated based on the lower of your usual and customary charge, and the maximum allowable rate.

- Beginning 4/1/99 date of service, the maximum rates for Routine Home Care and Continuous Home Care are based on the location of the patient on the date of service. For dates of service prior to 4/1/99, the location of your agency determines the maximum allowable rates for these two services.

- The maximum allowable rate for the other Hospice services is determined by the location of your agency.

NOTE: *When a nursing facility resident elects Hospice, your agency is responsible for collecting the PML from the patient. The amount Medicaid pays you for a nursing facility patient's Hospice care is reduced by the amount of the PML.*

8.15.4 Annual Inpatient Care Limit

There is an annual limit on the total amount of payments that your agency may receive for inpatient care (Inpatient Respite Care and General Inpatient Care) for all of your Medicaid patients, except those with acquired immune deficiency syndrome (AIDS). Hospice care provided for patients with AIDS is excluded in calculating the limit on inpatient care payments.

The limit is applied for services provided November 1 of the previous year through October 31 of the current year. When the number of days of inpatient care exceeds 20 percent of the total days of care during that period, your payments are adjusted. The process is:

- The number of days that Medicaid paid you for Hospice in the period is totaled.

- The total is multiplied by .2 (20%) to determine the maximum allowable days of inpatient care.

- The number of days you were paid by Medicaid For Inpatient Respite Care and General Inpatient Care is totaled. The sum is compared to the above result.

  - If the total of inpatient days **does not exceed** 20 percent of the total days of coverage, no adjustment is made.

  - If the total of inpatient days **exceeds** 20 percent of the total days of coverage, the adjustment is calculated as follows:

Step 1 Divide the maximum allowable number of inpatient care days by the number of paid inpatient days.

Step 2 Multiply the result of Step 1 by the total amount you received for inpatient care.

Step 3 Multiply the number of excess inpatient days (the number over the maximum allowable) by the routine home care rate.

Step 4 Add the results of Steps 2 and 3.

Step 5 Subtract the result of 4 from the total amount you received for inpatient care. The result is the excess to be refunded to Medicaid.

REMEMBER: *Do not include Hospice care provided for AIDS patients in calculating the limit on inpatient care payments.*

8.15.5 Filing a Claim

Use the UB-92 for your claim. Follow the instructions in Section 14.

REMEMBER: *Effective April 1, 1999, date of service, billing for Routine Home Care and Continuous Home Care is based on the location of the patient for each date of service. If the patient receives these services under Medicaid in multiple MSA areas, a claim for each area must be submitted. For example, if a patient who resides in Johnston County (MSA Code 6640) receives Routine Home Care at his home for 22 days in the month and the other days of the month is hospitalized in Wake County (MSA Code 66406) for care not related to the terminal illness, separate claims must be submitted. One claim is for the Routine Home Care in Johnston County and the other claim is for the Routine Home Care while hospitalized in Wake County.*

For the care in Johnston County, form locator 40 should appear as follows:

40 CODE	VALUE CODES AMOUNT	
61	6640	

For the care in Wake County, form locator 40 should appear as follows:

40 CODE	VALUE CODES AMOUNT	
61	66406	

Hospice Q & A

The following include some of the common questions about providing Hospice and answers to those questions.

1. Q. Are Medicare-certified hospice agencies automatically enrolled with Medicaid as providers?

A. No, you must request enrollment with Medicaid. See Section 19 for provider enrollment information.

2. Q. Dr. Jemison serves as our hospice's medical director on a voluntary basis. He does not provide any direct patient care services on a voluntary basis. He is the attending physician for Mary Jones, one of our hospice patients. Should our agency bill Medicaid for the direct patient care services provided by Dr. Jemison?

A. No. Dr. Jemison bills Medicaid directly for the direct patient care services. The attending physician bills Medicaid for direct patient care services unless the services are provided on a volunteer basis. A physician may not bill Medicaid if he provides the same services on a volunteer basis to non-Medicaid patients.

3. Q. Is our agency responsible for transporting a patient by ambulance from his home to a hospital?

A. Yes, when ambulance transportation for a Hospice patient is necessary for the palliation and management of the terminal illness and related conditions, it is a covered Hospice service.

4. Q. Is our agency required to provide continuous home care during periods of medical crisis?

A. Yes. You are required to provide all of the services in the Hospice package that are needed by the patient.

5. Q. Is there a limit on the total number of days that an individual patient may receive Hospice?

A. No. Each of the first two benefit periods are limited to 90 days. There is no limit on the 60-day periods as long as the patient meets the requirements for the Hospice benefit. At the beginning of each benefit period, the patient must be certified as terminally ill with six months or less to live. If the patient no longer meets that criterion, you may not continue to bill hospice services to Medicaid.

6. Q. We had a patient who died before signing a Medicaid election statement and before Medicaid eligibility was established. The patient has since been found to be eligible for Medicaid. May we bill Medicaid?

A. No. A patient or his representative must sign the election statement prior to the effective date of the benefit period. If you are unsure of a patient's Medicaid status and intend to provide the full Medicaid Hospice coverage, you may wish to have the election statement signed -see Question 7.

7. Q. We had a patient who signed the Medicaid election statement and applied for Medicaid two days later. His Medicaid eligibility was not established until after he died. May we bill for Hospice services?

A. If you provided the care according to the Medicaid Hospice benefit -that is, the covered services needed by the patient according to the patient's plan of care – and you reported Hospice participation to EDS within the reporting time limit, you may bill for Hospice services from the Medicaid authorization date to the date of death.

8. Q. Is our agency responsible for covering all medical appliances, supplies, drugs and procedures ordered by the hospice patient's attending physician?

A. No. Medical appliances, supplies, drugs and procedures necessary for the relief of pain and symptoms related to the terminal illness and included in the patient's POC are covered hospice services. The patient, the physician and your agency determine the specific services to be included in the POC and provided by your agency.

9. Q. Can a nursing facility resident elect Hospice if the facility does not have a contract with a hospice agency?

A. No. The patient must be in a facility that has an arrangement with a hospice agency. If an nursing facility resident seeks Hospice in such a situation, you are encouraged to work with the facility.

10. Q. How is the level of care – intermediate care facility (ICF) or skilled nursing facility (SNF) – established for a hospice patient residing in a nursing facility? Do hospice patients automatically qualify for SNF care?

A. The nursing facility establishes the appropriate level of care for a hospice patient just as they do for all nursing facility patients. They use the FL-2 process. A terminal illness does not automatically qualify a patient for SNF level of care.

11. Q. Does a rest home patient's receipt of state and county Special Assistance for adult care home residents effect Hospice coverage?

A. No. Special Assistance has no effect on Hospice coverage.

12. Q. We have a request for Hospice from a patient in a rest home bed in a combined rest home and nursing facility. Must the patient be moved to an nursing facility bed to get Hospice?

A. No. An adult care home (rest home) patient receives Hospice the same as if he was in a private residence. You are paid the appropriate home care rate. The patient's room and board continues to be paid as it was before the patient went on Hospice. Patients are moved to nursing facility beds only when the need for a higher level of care exists and a nursing facility level is approved by EDS.

13. Q. When a hospice patient in a nursing facility is hospitalized, will Medicaid still pay for the patient's room and board at the nursing facility?

A. No. Medicaid does not pay a "bed hold" rate to the nursing facility or to your agency when a patient is hospitalized.

14. Q. When a patient resumes Medicaid coverage for Hospice after being in deductible status or ineligible for a time, must he begin a new benefit period?

A. Whether a patient must begin a new benefit period when he resumes Medicaid coverage of Hospice after being on a deductible or ineligible for a time, depends upon whether he continued to be a hospice patient during the period of ineligibility.

- If he continued as a hospice patient, regardless of the funding source, and the charges were applied towards the Medicaid deductible, he resumes coverage at the point in the benefit period where he would be if he had been receiving Medicaid Hospice coverage all along. For example, if a patient becomes ineligible for Medicaid coverage after receiving 44 days of hospice care in the first benefit period, and regains Medicaid eligibility 30 days later, then he re-enters at day 74 of the benefit period.
- If he discontinues hospice care while he was ineligible for Medicaid coverage, the situation is handled like a revocation of hospice care. He loses all of the remaining days in the current benefit period. If a patient wants to re-elect Medicaid coverage of Hospice when he regains eligibility, he must begin a new benefit period. Remember to report both the discontinuance and resumption of Hospice to EDS.

15. Q. If a hospice patient goes into the hospital while on spenddown, is our agency liable for the hospital bill?

A. Your agency should treat a patient on a spenddown like a private pay patient.

16. Q. Is our agency required to provide all home health aide and homemaker services needed by the hospice patient or may some aide services be provided through Personal Care Services (PCS)?

A. The hospice agency is expected to provide all home health aide and homemaker services related to the terminal illness according to Medicare and Medicaid regulations. Hospice home health aides and homemakers can do all of the tasks allowed under PCS.

17. Q. If a patient has only ***Medicaid*** coverage for Hospice care, can he participate in CAP/DA?

A. When a patient has Medicaid Hospice coverage, the total cost to Medicaid for Hospice counts towards the CAP cost limit. The cost to Medicaid for Hospice would likely exceed the CAP cost limit, thereby, preventing CAP participation. The CAP case manager and the hospice agency's care coordinator may wish to explore alternatives to having the patient formally elect Medicaid Hospice coverage. Hospices may obtain information on the CAP programs, including cost limits applicable to specific CAP programs and levels of care, from the local CAP case manager, or from DMA's CAP unit at the telephone number in Appendix B.

18. Q. May a hospice patient covered by ***Medicare*** be considered for CAP/DA participation?

A. Yes. Your agency and the CAP/DA case manager determine the needs of the patient that are not included in the Hospice benefit. Remember, CAP/DA cannot provide services that duplicate or replace the care that is the responsibility of the hospice agency.

In addition to CAP/DA Case Management, a Medicare Hospice patient maybe considered for the following services from CAP/DA:

- Adult Day Health
- Telephone Alert
- Home Mobility Aids
- In-Home Respite
- Home Delivered Meals
- Medication Dispensing Boxes and Oral Nutritional Supplements under CAP/DA Waiver Supplies

The Medicare hospice patient may also be considered for CAP/DA In-Home Aide Services if they do not duplicate the hospice home health aide and homemaker services the hospice agency is required to provide. There are differences between Hospice home health aide and homemaker services and the CAP/DA In-Home Aide Services. Hospice home health aide and homemaker services include assistance with personal care and home management tasks during a scheduled visit. CAP/DA aides' duties are broader in that they may also substitute for the family or caregiver during an absence. The CAP/DA aide may spend time supervising or monitoring the client, assisting with medications as permitted and similar tasks that extend over several hours. The hospice agency and CAP/DA case manager coordinate the aide services to avoid duplication.

19. Q. When a hospice patient with Medicaid coverage enters a nursing facility, must the patient be in a Medicaid-certified bed?

A. Yes.

20. Q. When a hospice patient in a nursing facility requests "therapeutic leave" to be with family members at home, can the hospice bill for room and board in addition to the home care rate?

A. Yes. A Medicaid hospice patient occupying a nursing facility bed may take up to 60 days of therapeutic leave from the facility in a calendar year. Therapeutic leave must be ordered by the patient's physician and is for therapeutic purposes only. Therapeutic leave may not be taken for purposes of receiving inpatient or nursing services provided either elsewhere or at a different level of care in the facility of residence when such services are or will be paid for by Medicaid. If more than 15 consecutive therapeutic leave days are needed by the patient, request approval from EDS' Prior Approval Unit (1-800-688-6696).

The hospice documents the necessity for therapeutic leave in the patient's plan of care and justification for each period of therapeutic leave in the patient's records. The hospice reimburses the nursing facility for therapeutic leave days according to the terms of their contract. While the patient is on therapeutic leave, the nursing facility must reserve the patient's bed and may not derive any Medicaid revenue for the bed besides that paid to the facility by the hospice for the period of absence.

21. Q. Our home care and hospice agency has enrolled with Medicaid to provide Hospice Services and CAP In-Home Aide Services. To date, we have provided CAP In-Home Aide Services for hospice patients only. May our agency limit our acceptance of CAP participants to those who need hospice care?

A. Medicaid policy does not prevent you from limiting your acceptance of CAP participants to those who are terminally ill. Describe the population(s) your agency will serve and any limitations in your agency's policies.

22. Q. A terminally ill patient has elected the Medicaid Hospice benefit. He also has private insurance coverage for hospitalization. In the following situations, should the hospice agency bill Medicaid for Hospice care and how does the hospital get paid?

Situation A - the patient is hospitalized for a curative treatment for the terminal condition.

Situation B - the patient is hospitalized for palliative care for the terminal illness, such as pain management.

Situation C - the patient is hospitalized for a condition not related to the terminal illness.

A. **Situation A** - Medicaid will not pay for the hospital care provided. By electing the Hospice benefit, the patient declines further curative treatments and waives the right to Medicaid payment for treatments for the terminal condition which duplicate Hospice care. The hospice may bill Medicaid the Routine Home Care rate as long as the benefit election is in effect, but the hospice should advise the patient to revoke the Hospice benefit if he wants to seek curative treatments. The patient may resume Hospice care later by re-electing the Hospice benefit if any benefit periods remain. The third party insurer should be billed for the hospital care in this situation.

Situation B - The hospice may bill Medicaid the General Inpatient rate or the admission since Hospice care, not hospital care, is being provided. The hospice should reimburse the hospital according to the terms of their contract.

Situation C - The hospice may bill Medicaid the Routine Home Care rate during the admission to cover ongoing Hospice activities. Hospital care unrelated to the terminal illness is not waived during the Hospice benefit. The hospital bills the third party and Medicaid according to Medicaid policies and procedures for hospital coverage.

23. Q. A hospice patient elected the Medicaid Hospice benefit on March 15, but his certification period for Medicaid eligibility will end March 30. The patient must meet a deductible to be Medicaid eligible again. Must the patient revoke the Medicaid Hospice benefit on March 30 and begin a new benefit period when he becomes Medicaid eligible again?

A. The patient is not required to revoke the Hospice benefit because he has a deductible or is ineligible for Medicaid for a time. Whether the patient must begin a new benefit period when he resumes Medicaid coverage depends upon whether he continued to be a hospice patient during the period of ineligibility. See Question 14.

24. Q. If a hospice continues providing services when a Medicaid patient goes into deductible status, should the hospice bill the patient a per diem rate or fee-for-service?

A. Medicaid patient in deductible status is a private pay patient and should be billed in the same manner as other private pay patients. If the hospice bills private pay patients a fee-for-service, it must bill the Medicaid deductible patient in the same circumstances in the same manner. If the hospice bills private pay patients a per diem, it must bill the Medicaid deductible patient in the same circumstances in the same manner.

Note that not all the services in the Hospice benefit may be applied to the patient's deductible if the services are billed on a fee-for-service basis. Only medical services covered by Medicaid or medical expenses recognized under state law may be applied to a Medicaid deductible. "Recognized under state law" means an expense that may be used as a medical deduction under tax law. Hospice medical social work and counseling are covered as part of the Hospice benefit, but not otherwise by Medicaid. Hospice medical social work and counseling are also not recognized as medical expenses under IRS Publication No.502. Therefore, if the hospice bills the deductible patient by fee-for-service, the bills for medical social work and counseling may not be applied to the deductible.

25. Q. XYZ Hospice uses a sliding scale to bill fees-for-services. For a hospice nursing visit, XYZ Hospice may charge from $5 up to its "usual and customary" charge to the public of $50. Could the hospice bill a Medicaid deductible patient the "usual and customary charge" if it is greater than the fee-for-service some other individuals are charged by the sliding scale and could that "usual and customary charge" be used to meet the deductible?

A. The amount that may be applied to the deductible is the amount the patient is expected to pay. If the hospice uses a sliding scale to bill a Medicaid deductible patient, the charge should be based on the patient's circumstances just as for any other patient. A Medicaid deductible patient would be charged the same amount as a non-Medicaid patient in the same circumstances. As long as the amount charged is for a medical service covered by Medicaid or a medical expense recognized under state law, and expected to be paid, it may be applied to the Medicaid deductible.

26. Q. Do we need to send a copy of the patient's Hospice election statement with the first claim that we send to EDS?

A. No. The requirement was discontinued when Hospice participation reporting was initiated. This change allows all Hospice claims to be submitted electronically.

27. Q. Do I need to report termination of Hospice to EDS when a patient dies?

A. No. The patient's date of death is put in the system through the Eligibility Information System.

28. Q. I have a patient who has elected the Hospice Medicaid benefit; however his Medicaid is still pending. When do I call to report the patient's election to EDS?

A. When you encounter this situation, you will need to make two telephone calls to the EDS Prior Approval unit.

1. Make the initial call within the six-day time frame when the patient elects Hospice.

2. When the patient's Medicaid is approved, call EDS and let them know this patient was previously reported as a pending Medicaid patient. EDS will then give you a confirmation number that dates back to your original telephone call.

29. Q. I have a Medicaid Hospice patient whose next benefit period starts next Monday. I am sure the patient will re-elect Hospice. Because I will be on vacation next week, I would like to call the election in to EDS on Friday. May I do so?

A. No. You may not call in the election of a new benefit period until the date the patient re-elects Medicaid Hospice.

30. Q. Our Hospice admitted a patient on October 1, 2000. The office manager was out of town and could not call EDS until March 14, 2000. Can we get a retroactive confirmation number?

A. No. Hospice agencies must make sure they have a procedure to report all patients within the six-day grace period.

31. Q. I have a patient with Medicare and Medicaid. The patient has elected both Medicare and Medicaid Hospice. The patient is at home and I do not expect to bill Medicaid. Do I need to call this patient's information to EDS?

A. No. It is not required to call EDS unless you are planning on billing Medicaid.

32. Q. The patient who has elected Medicare and Medicaid Hospice has now decided to enter a nursing facility. Our agency will need to begin billing Medicaid for the room and board. When do we need to call EDS for a confirmation number?

A. You must call EDS within six days of the patient's admission to the nursing facility. Give EDS the date of admission as the benefit start date and the end date for the current Medicare benefit period as the benefit end date.